COMPLETING THE HCFA-1500 FORM

MONTANA MEDICAID
August 1998

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Montana Medicaid Consultec

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PROVIDER MANUAL UPDATE

TO: All Participating HCFA-1500 Billers

FROM: Consultec, Inc.

DATE: August 1, 1998

SUBJECT: New Medicaid HCFA-1500 Billing Instructions

****

Enclosed is revised set of HCFA-1500 billing instructions for Medicaid claims. There are three specific areas that providers will want to pay particular attention to:

FIELD 10d (Reserved for Local Use):

Medicare and some private insurance companies have instructed you to enter the Medicaid ID # in this field. To be consistent with other payers' instructions, Medicaid is adopting the use of this field. Therefore, when Medicaid is the secondary payor you must use this field for the Medicaid ID #.

FIELD 21/24E (Diagnosis Codes and Reference Numbers):

In field 21 enter up to four ICD-9-CM diagnosis codes in priority order. In field 24E you must enter the diagnosis code reference number from field 21. Only the specific reference numbers (1, 2, 3, 4) will be accepted in field 24E.

FIELD 24H (EPSDT/Family Planning):

The values for this field have been expanded. The appropriate values in this field are used to override copay, exempt services from PASSPORT authorization, override benefit limitations for children, and override Medicare edits on oxygen services for nursing home recipients. Please review the instructions for this field thoroughly. We will no longer override copay based on information listed in field 19.

Please review the updated manual and pass it along to billing personnel for their review. If you have questions about HCFA-1500 billing instructions, please contact Consultec Provider Relations at 1-800-624-3958 or 406-442-1837.

PROVIDER MANUAL SECTIONS

Montana Medicaid instructions have been divided into four sections for easier reference. The four sections are:

Section I	-	Medicaid ONLY Claims
Section II	-	Medicare/Medicaid, Medicare/QMB or TPL*****/Medicaid Claims
Section III	-	TPL#/Medicare/Medicaid Claims
Section IV	-	Medicare/Medicare Supplement/Medicaid Claims

 # TPL means "third party liability" or private insurance.

Fields with an * are required fields; all others are optional for Medicaid purposes. Refer to the sample HCFA-1500 (12/90) claim form on page 9 for the location of the numbered fields. If you have any questions, please contact provider relations at 1-800-624-3958 (Montana toll-free) or (406) 442-1837.

I. MEDICAID ONLY CLAIMS

FIELD NUMBER/NAME		INSTRUCTIONS
1a.*	Insured's I.D. Number	Enter the patient's **Medicaid number** as shown on the Medicaid Identification Card.
2. *	Patient's Name	List the patient's last name, first name, and middle initial as they appear on the Medicaid Identification Card.
3.	Patient's Birth Date & Sex	Enter the patient's date of birth (MM/DD/YY) and sex.
5.	Patient's Address	Enter the patient's address.
10.	Is Patient's Condition Related To:	Check "YES" or "NO" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in Field 24. Enter the appropriate 2 letter state abbreviation.

FIELD NUMBER/NAME		INSTRUCTIONS
11d.*	Is There Another Health Benefit Plan?	Check "NO" (If the answer to this question is "YES", you must follow the appropriate instructions in Section II, III or IV.)
14.	Date of Current Illness, Injury or Pregnancy	Enter Date (MM/DD/YY).
16.	Dates Patient Unable to Work in Current Occupation	Enter Dates (MM/DD/YY) if patient is unable to work.
17.	Name of Referring Physician or Other Source	Enter the name of the referring physician or other source. If the patient is on "PASSPORT TO HEALTH", enter the name of their PASSPORT assigned primary care provider if billing for a PASSPORT managed service.
17a.*	I.D. Number of Referring Physician	Enter the referring or ordering physician's Medicaid Provider Number. **If the patient is on "PASSPORT TO HEALTH", and the billing is for PASSPORT managed care services, the PASSPORT provider's Medicaid provider number or UPIN must be entered here.**
18.	Hospitalization Dates Related to Current Services	Enter dates (MM/DD/YY) if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
20.	Outside Lab?	Check "NO". Medicaid requires all lab tests to be billed directly by the provider who actually performed them.
21.*	Diagnosis or Nature of Illness or Injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to 4 codes in priority order (primary, secondary, etc.).

FIELD NUMBER/NAME		INSTRUCTIONS
23.*	Prior Authorization Number *** This field is mandatory when the service/supply requires prior authorization.**	If the service billed requires prior authorization, enter the prior authorization number you received for this service. The prior authorization number is a unique ten (10) digit number. Refer to your Provider Manual
24A.*	Date(s) of Service	Enter date(s) of service **(MM/DD/YY)** for each procedure, service or supply. **NOTE: Field 24 is designed for reporting 6 lines of information. If you need to report more than 6 services, please use another form.**
24B.*	Place of Service	Enter the appropriate **two digit** place of service code from the list in Appendix A (attached).
24C.*	Type of Service	Enter the Type of Service (TOS) Code from the list in Appendix B.
24D.*	Procedures, Services or Supplies	Enter the appropriate CPT-4/HCPCS code for the procedure, service or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. **Up to three modifiers per procedure code are allowed. Please refer to your specific Provider Manual section for details on modifier use.**
24E.*	Diagnosis Code	Enter the diagnosis code reference number (1,2,3, or 4) shown in Field 21 as they apply to each line of the claim. **ONLY THE SPECIFIC REFERENCE NUMBERS WILL BE ACCEPTED.** **Do not enter the ICD-9-CM diagnosis code in this field.**
24F.*	$ Charges	Enter your usual and customary charge for the procedure(s) billed on this line, unless the Department has given you a specific charge amount to use for this procedure.

FIELD NUMBER/NAME	INSTRUCTIONS
24G.* Days or Units	Enter the number of units or days for the procedure and date(s) of service billed on this line. Anesthesia providers must bill using minutes.
24H.* EPSDT/Family Planning (COPAYMENT/PASSPORT OVERRIDE) **An entry of 2 in this field will override the Medicaid copayment on the line.** **An entry of 3, 4, or 5 in this field will override the Medicaid copayment on the claim.** **An entry of 2, 3, or 5 in this field will exempt the line from PASSPORT authorization.**	Enter the appropriate code for the patient's situation as follows: 1 = EPSDT/Kids Count [1] 2 = Family Planning 3 = EPSDT and Family Planning 4 = Pregnancy (Any service provided to a pregnant woman.) 5 = Pregnancy (For use in the PASSPORT program, obstetrical services only.) 6 = Nursing Home Patient [2] "Y" and "N" are not valid indicators.
24I.* EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room. An entry of "X" in this field will override the Medicaid copayment.
24K. Local Use	Not required.
28.* Total Charge	Enter the total charge for all services billed; this is the sum of all charges in 24F.

[1] An entry of 1 in this field will override benefit limits for persons under the age of 21 for this line.

[2] An entry of 6 will also override the Medicare edit for oxygen services on this line.

FIELD NUMBER/NAME		INSTRUCTIONS
29.	Amount Paid	Leave blank or enter $0.00. DO NOT ENTER PATIENT MEDICAID COPAY AMOUNTS OR ANY MEDICAID PAYMENT AMOUNTS IN THIS FIELD (OR ANYWHERE ON THE FORM). THESE AMOUNTS ARE NOT REPORTED BY THE PROVIDER AS CREDITS.
30.	Balance Due	Enter the balance due - this amount is the same as Field 28.
31.*	Signature of Physician or Supplier	This field **must** contain either: a. the provider's actual signature; b. authorized agent's signature; c. facsimile (rubber stamp) signature; or d. a computer generated name.
31.*	Date	This field must contain the date of the claim submission in MM/DD/YY format. (The submission must be dated on or after the last service date on the claim.)
32.	Name and Address of Facility Where Services Were Rendered	Enter name and address of the person, organization or facility performing the services if other than the patient's home or physician's office (i.e. hospital, clinic, laboratory, etc.).
33.*	Physician's, Supplier's Billing Name, Address, Zip Code and Phone #	Enter the name, address, phone number and **Montana Medicaid Provider Number** (not UPIN) of the physician or supplier who furnished services.

II. MEDICARE/MEDICAID, MEDICARE/QMB or TPL/MEDICAID CLAIMS

Follow instructions in Section I (Page 1) with the following exceptions:

FIELD NUMBER/NAME		INSTRUCTIONS
1a.*	Insured's I.D. Number	Enter the Medicare or other third party liability identification number.
4.	Insured's Name	Enter the name of the insured, except when the insured and the patient are the same - then the word "SAME" may be entered.
7.	Insured's Address	Enter the insured's address and telephone number, except when the address and telephone number are the same as the patient - then the word "SAME" may be entered.
10d.*	Reserved for Local Use	Enter the patient's **Medicaid ID #** as shown on the Medicaid Identification Card.
11.	Insured's Policy Group or FECA Number.	Enter "NONE"
11c.*	Insurance Plan Name or Program Name	Enter the name of the other insurance plan or program name (i.e. Medicare, BC/BS, etc.)
11d.*	Is There Another Health Benefit Plan?	Check "YES"
29.*	Amount Paid	Enter the amount actually paid by other insurance coverage or Medicare. Do not include any adjustment amounts in this field.
30.*	Balance Due	Enter the balance due.

III. TPL/MEDICARE/MEDICAID CLAIMS

Follow instructions in Section I (Page 1) with the following exceptions:

FIELD NUMBER/NAME		INSTRUCTIONS
1a.*	Insured's I.D. Number	Enter the Medicare identification number.
4.	Insured's Name	Enter the name of the insured, except when the insured and the patient are the same - then the word "SAME" may be entered.
7.	Insured's Address	Enter the insured's address and telephone number, except when the address and telephone are the same as the patient - then the word "SAME" may be entered.
10d.*	Reserved for Local Use	Enter the patient's **Medicaid** # as shown on the Medicaid Identification Card.
11.*	Insured's Policy Group or FECA Number	Enter the primary (TPL) payor's identification number.
11c.*	Insurance Plan Name or Program Name	Enter the name of the primary payor.
11d.*	Is There Another Health Benefit Plan?	Check "YES"
29.*	Amount Paid	Enter the amount paid by TPL payor (not Medicare)**only**. NOTE: Medicare payment amount will be determined from the EOMB attached to the claim.
30.*	Balance Due	Enter the balance due.

IV. MEDICARE/MEDICARE SUPPLEMENT/MEDICAID CLAIMS

Follow instructions in Section I (Page 1) with the following exceptions:

FIELD NUMBER/NAME		INSTRUCTIONS
1a.*	Insured's I.D. Number	Enter the Medicare Identification Number
4.	Insured's Name	Enter the name of the insured, except when the insured and the patient are the same - then the word "SAME" may be entered.
7.	Insured's Address	Enter the insured's address and telephone number, except when the address and telephone are the same as the patient's - then the word "SAME" may be entered.
9a.*	Other Insured's Policy or Group Number	Enter the insured's Medicare Supplement policy number.
9d.*	Insurance Plan Name or Program Name	Enter the name of the Medicare Supplement carrier.
10d.*	Insured's Policy Group or FECA Number	Enter the patient's **Medicaid #** as shown on the Medicaid Identification Card.
11c.*	Insurance Plan Name or Program Name	Enter "Medicaid".
11d.*	Is There Another Health Benefit Plan?	Check "YES".
29.*	Amount Paid	Enter the amount paid by Medicare Supplement Insurance **only**. NOTE: Medicare payment will be determined from the EOMB attached to the claim.
30.*	Balance Due	Enter the balance due (The amount in Field 28 less the amount in Field 29 and less the amount actually paid by Medicare).

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

APPENDIX A

PLACE OF SERVICE CODES AND DEFINITIONS

The following two digit place of service codes must be used on Medicaid claims. **Only two digit place of service codes will be accepted on HCFA-1500 claims submitted to Medicaid on paper.**

CODES	DEFINITIONS	DETAILED EXPLANATION
00 - 10	Unassigned	
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or local Public Health Clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Patient's Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13 - 20	Unassigned	
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require either hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

CODES	DEFINITIONS	DETAILED EXPLANATION
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27 - 30	Unassigned	
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	
41	Ambulance-Land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance-Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
43 - 49	Unassigned	

CODES	DEFINITIONS	DETAILED EXPLANATION
50	Federally Qualified Health Center	A facility located in a medically under served area that provides preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: - Outpatient services; - 24 hour a day emergency care services; - Day treatment, other partial hospitalization services, or psychosocial rehabilitation services; - Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and - Consultation and education services.
54	Intermediate Care Facility/ Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57 - 60	Unassigned	

CODES	DEFINITIONS	DETAILED EXPLANATION
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology.
63 - 64	Unassigned	
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or care givers on an ambulatory or home-care basis.
66 - 70	Unassigned	
71	State or Local Public Health Clinic	A facility maintained by either State or Local departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural, medically under-served area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	
99	Other Unlisted Facility	Other service facilities not identified above.

APPENDIX B

TYPE OF SERVICE CODES

The following list of type of service codes must be used in billing Medicaid. The type of service code is reported in field 24C of the HCFA-1500 claim form. **Type of Service codes are**

required on Medicaid claims.

PROVIDER TYPE	AFTER 8/1/97 Dates of Service TYPE OF SERVICE CODE
Ambulance Services, Air or Land	0
Ambulatory Surgical Center	0
Audiology	0
Chemical Dependency Treatment	0
Chiropractors -QMB	0
Dental (for surgery and other procedures where the dentist bills on the HCFA-1500 form.)	0
Durable Medical Equipment(D.M.E.) Rental Purchase	 0 0
E.P.S.D.T. - (Chiropractors, Nutritionists, Private Duty Nursing, Respiratory Therapy, School Districts, etc.)	0
Family Planning Centers	0
Hearing Aids Rental Purchase	 0 0
Home Dialysis Attendant	0
Independent Laboratories	0
Licensed Clinical Social Workers	0
Licensed Professional Counselors	0
Medical Supplies ***** *** Billed by Medical Supply Providers**	0
Mental Health Centers	0
Mid-Level Practitioners	0
Non-Emergency Transportation	0
Nurse Specialists	0
Nursing Home Ancillaries & Coinsurance Days	9
Occupational Therapy	0
Opticians & Optometrists	0

PROVIDER TYPE	AFTER 8/1/97 Dates of Service TYPE OF SERVICE CODE
Oxygen Rental Purchase	0 0
Personal Care ***** *** Both Regular Medicaid and Waiver Medicaid patients**	0
Physical Therapists	0
Physicians & Osteopaths	0
Physician Assistants	0
Podiatrists	0
Private Duty Nursing	0
Psychologists	0
Public Health Agencies	0
Speech Therapists	0
Targeted Case Management	0
Transportation Mileage and Per Diem	0
Waiver (Home & Community Based Services)	0